Healthy Northeast Access Program

The University of Scranton

Center for Public Initiatives

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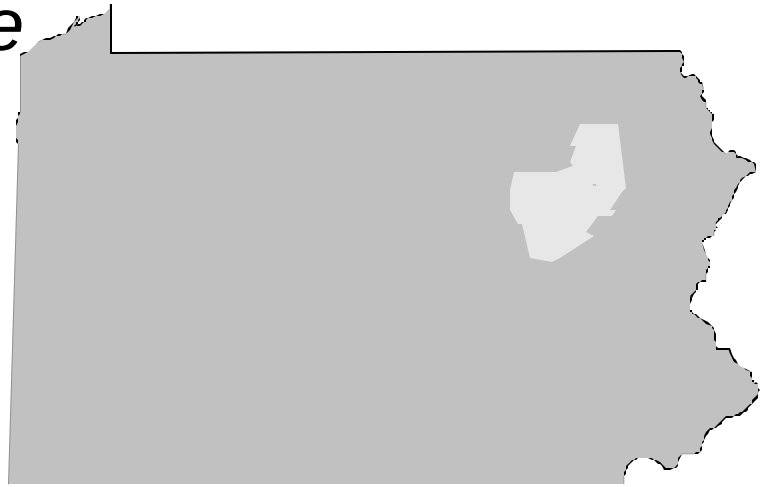
Northeast Pennsylvania

- Primary Service Area
  - *Scranton/Wilkes-Barre*
- Population - 500,000
  - *Region = 1 million*
- Uninsured - 55,000

  Medicaid - 50,000

  Medicare - 100,000 (high morbidity)
- Small Employer Area



Healthy Northeast
ACCESS PROGRAM

Northeast PA Community Need

- Economically depressed area - 40% of population on edge of poverty.
- High elderly population.
- 23% inability to pay for physician visit.
- 55,000 uninsured - 15,000 seeking care.
- Inappropriate use of emergency department.
- Poor health choices - sedentary life style.
- Issues with dental services/pharmaceuticals.

Major Themes of the Project

- Expanding access through core and referral partners
- Creating a comprehensive system of care
- Coordinated Care
- Maximizing Existing Resources
  - 100% Access, 0% Disparity

Core Partners and Referral Partners

Core Partners – Primary Care

1. Scranton Primary Health Care - FQHC
2. Rural Health Corporation of Northeastern Pennsylvania - FQHC
3. Scranton-Temple Health Center
4. Wyoming Valley Family Practice Residency Program

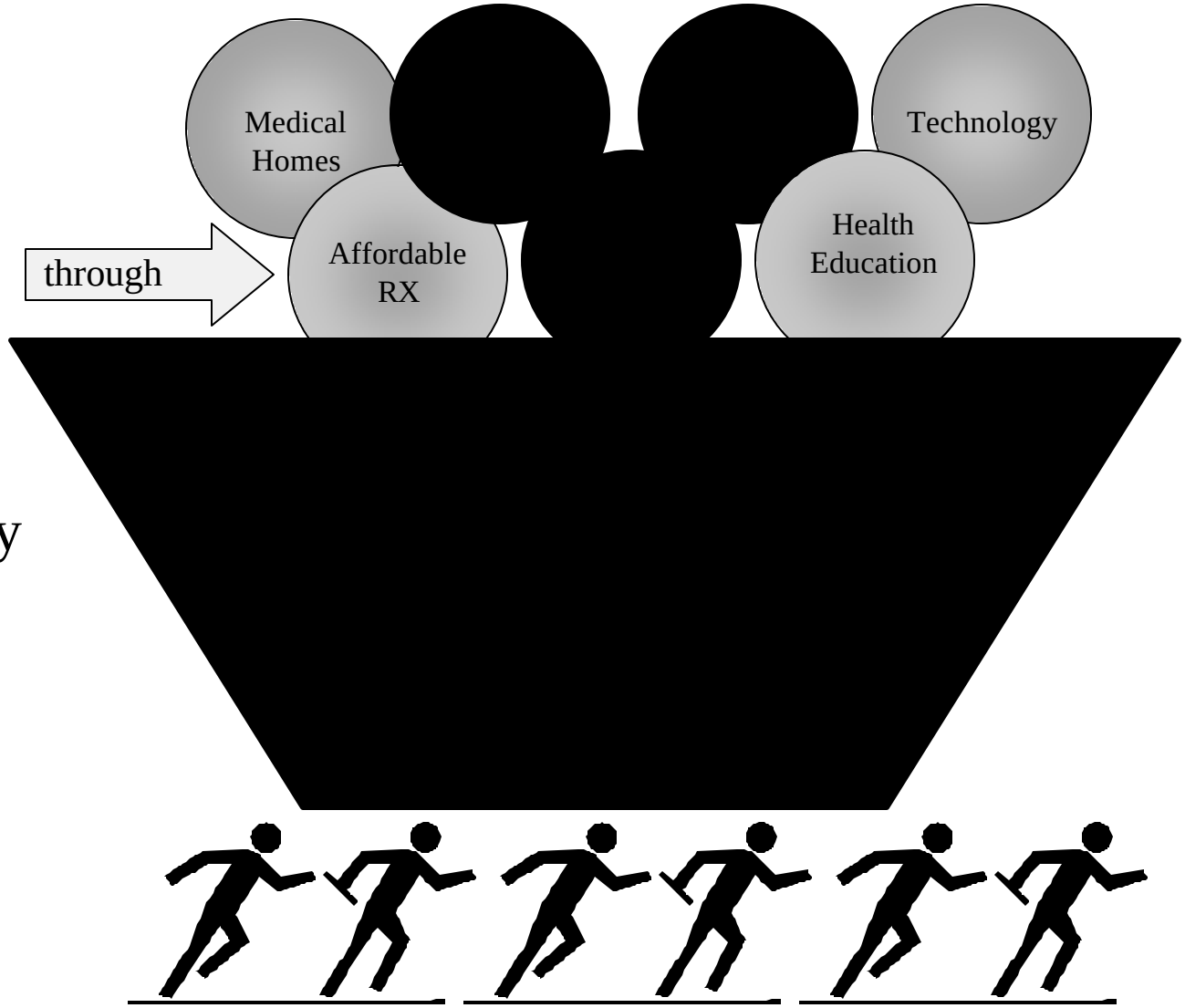
Referral Partners

55 Signed Memorandum of Understanding with Community Organizations

Project Objectives

- Develop outreach strategies for the uninsured and underinsured population of NEPA;
- Use electronic technology to improve care coordination between core and referral partners of the Healthy Northeast Access Program;
- Improve the health status of citizens of Northeastern Pennsylvania through optimal use of community resources;
- Increase access to dental services; and
- Increase availability of pharmaceutical products.

Better Health through



At *Less Cost* by

What Data do we Need?

Begin with the End in Mind…….

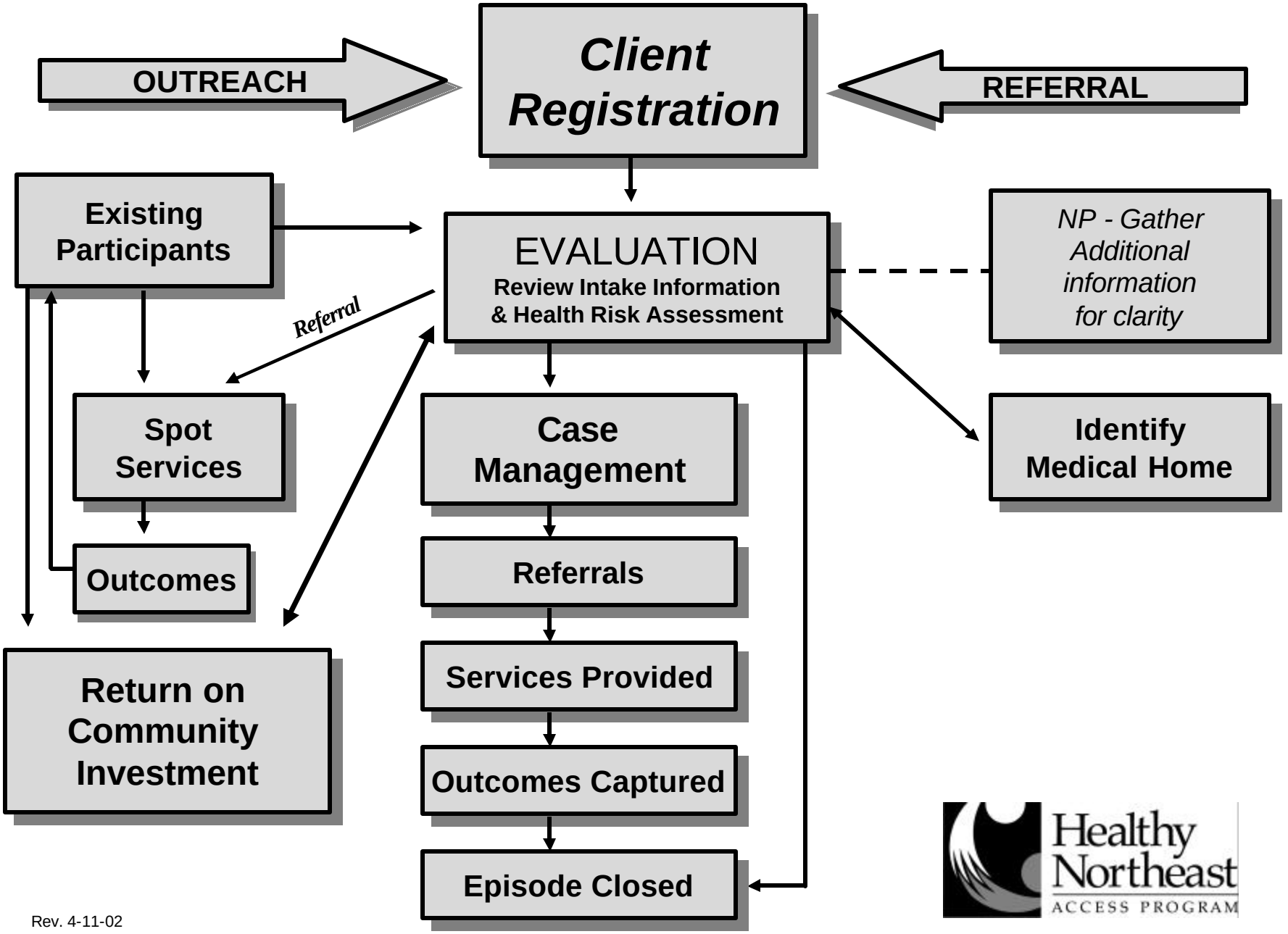
- What is it we need to capture for HRSA reporting requirements?
- What other outcomes would we like to capture for collaborative members, other funding sources, media, etc.
- How can we build a new data system to capture this information?
- How can we adapt our current system?
- How do we make modifications if/when the reporting requirements change?

Designing the Model

What's needed for effective care coordination:

- A comprehensive view of the client
- A way in which to focus on highest need/risk
- Community resources at your fingertips
- The ability to easily assign, capture and follow up on referrals to outside providers and agencies
- Information sharing with partners

Care Coordination Model

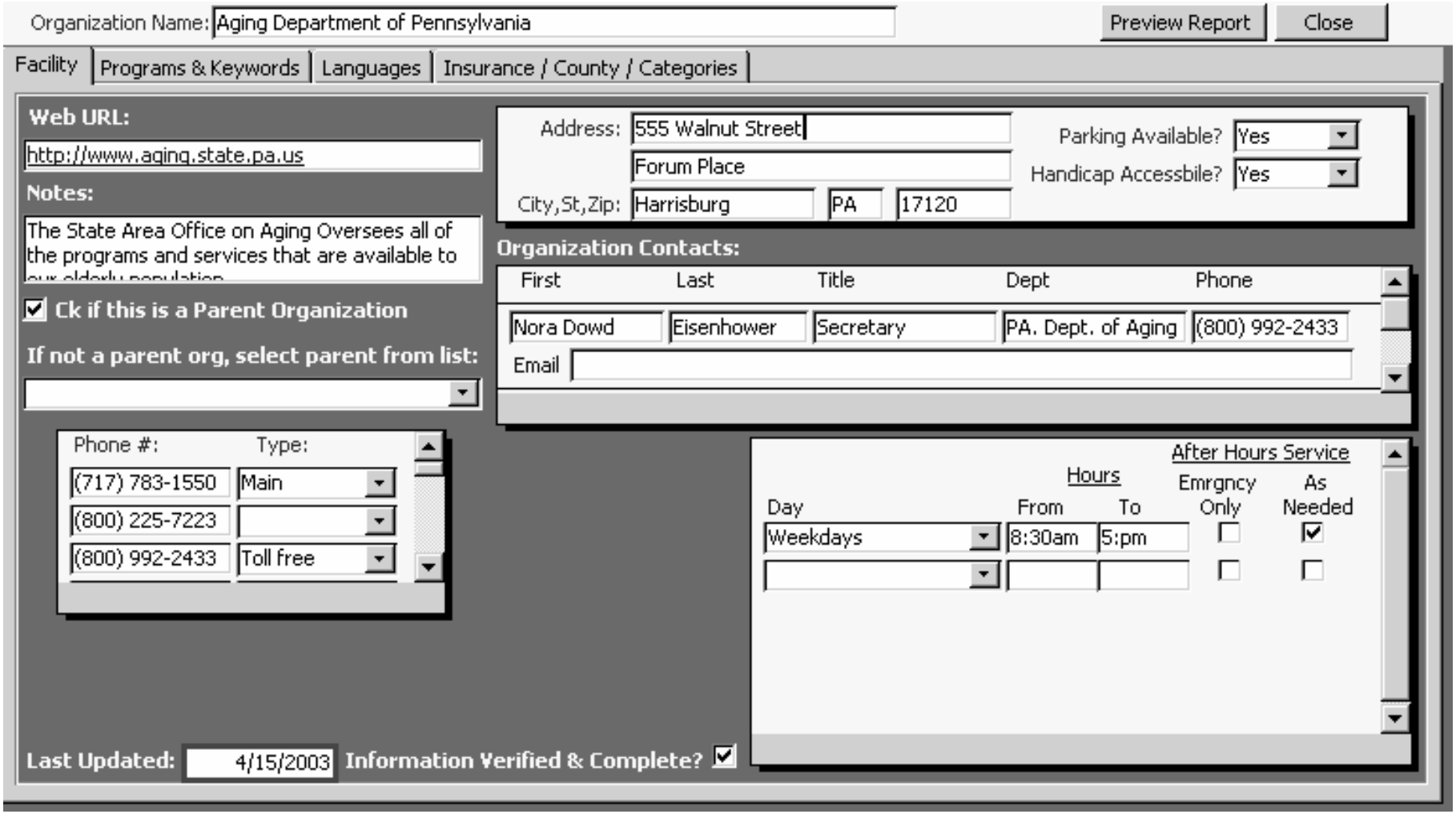


Healthy Northeast ACCESS PROGRAM

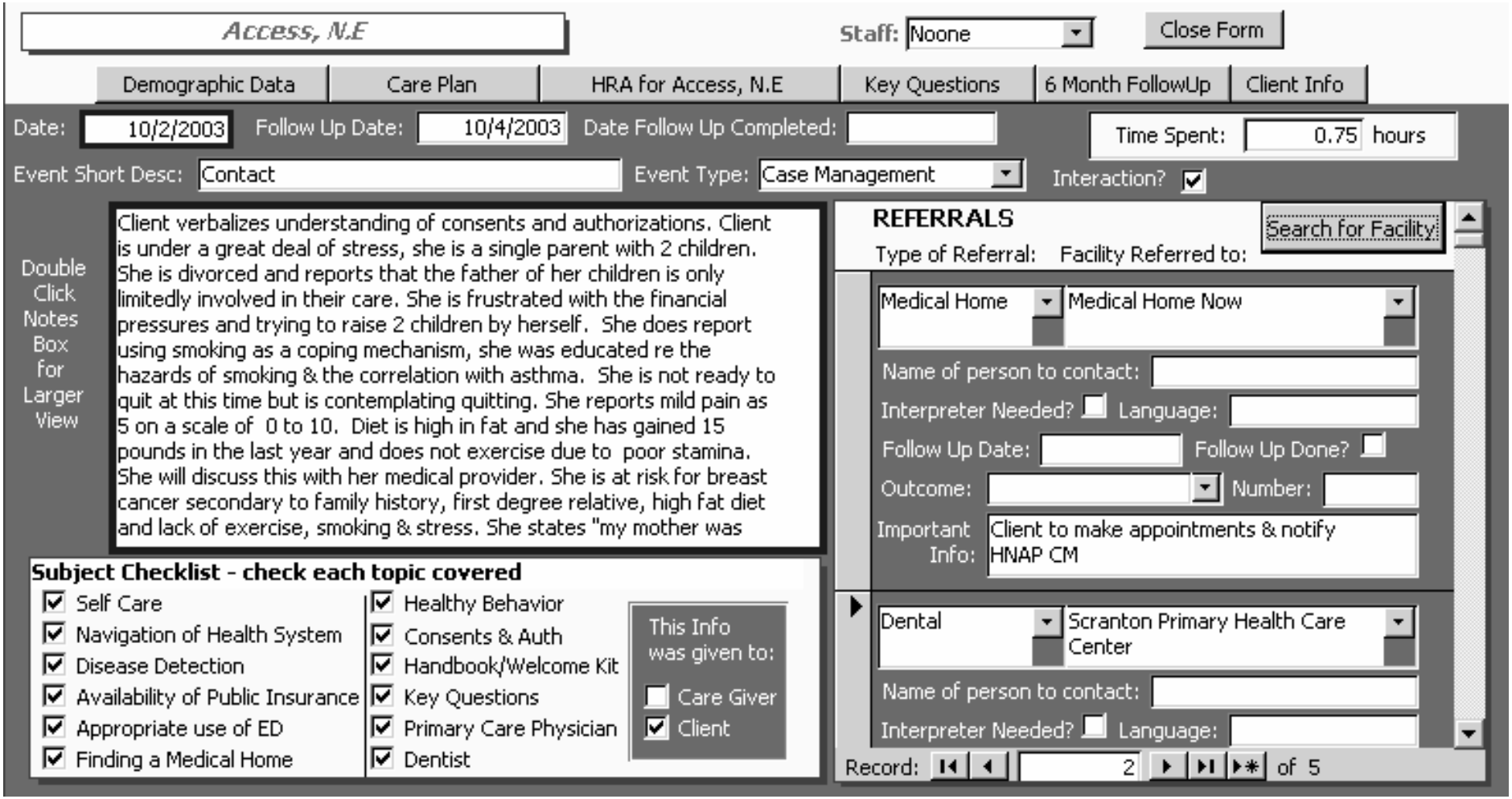
Rev. 4-11-02

Gathering the Output Data

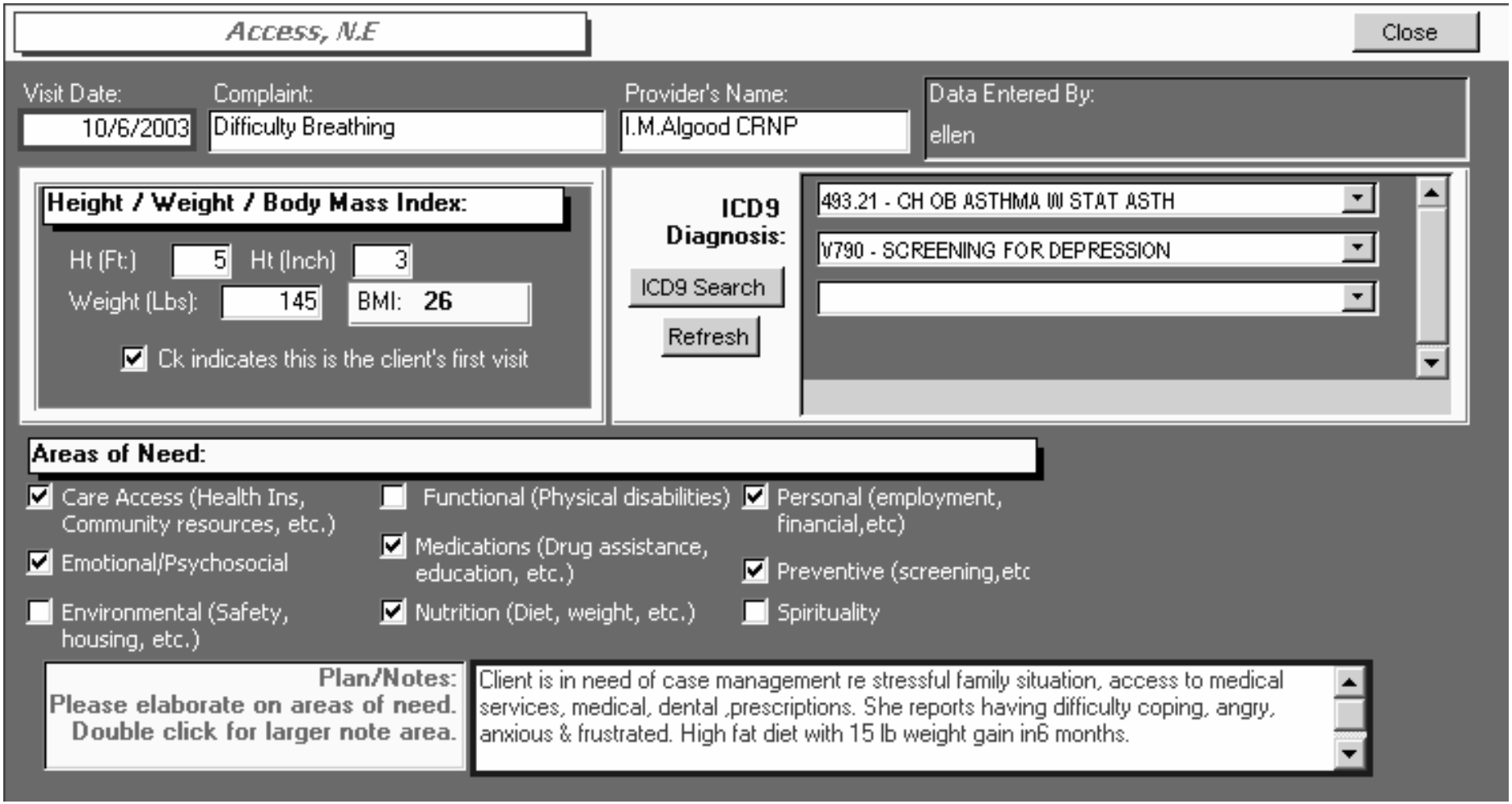
Finding the Resources



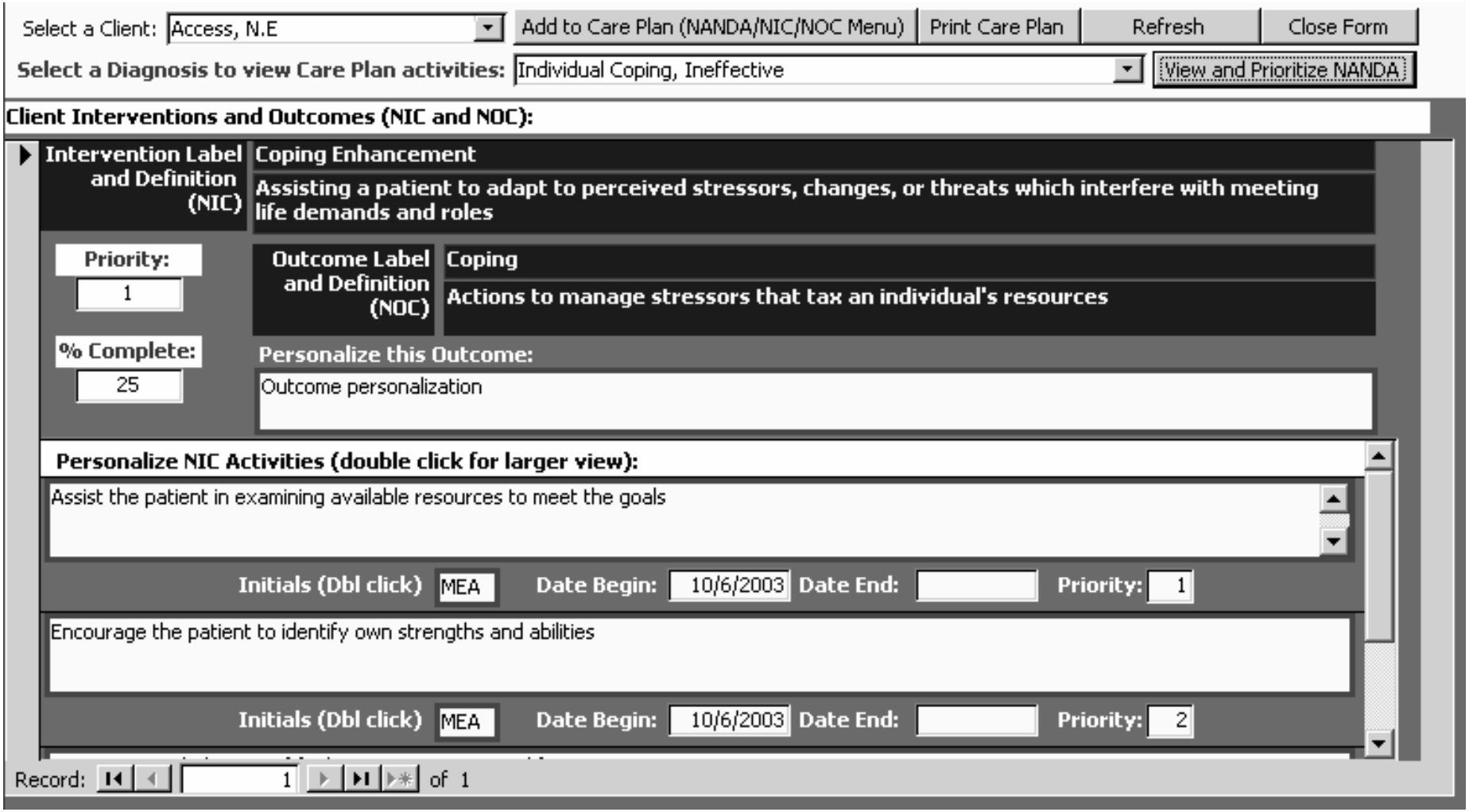
Organizing the Data



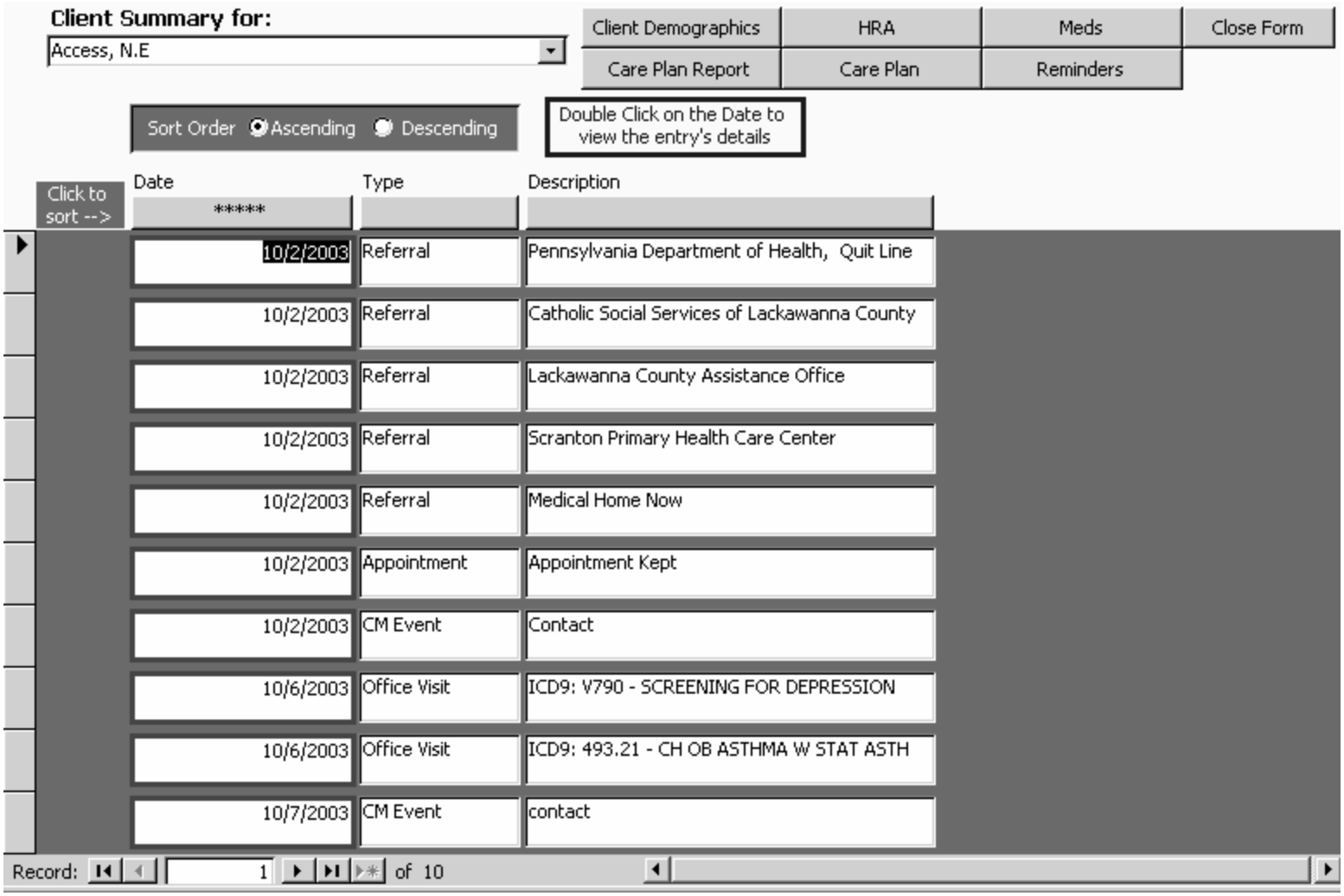
Sharing the Data



Evaluating the Progress



Reporting the Data



Feedback to Stakeholders

- Return on Community Investment

  Program Outcomes must show:

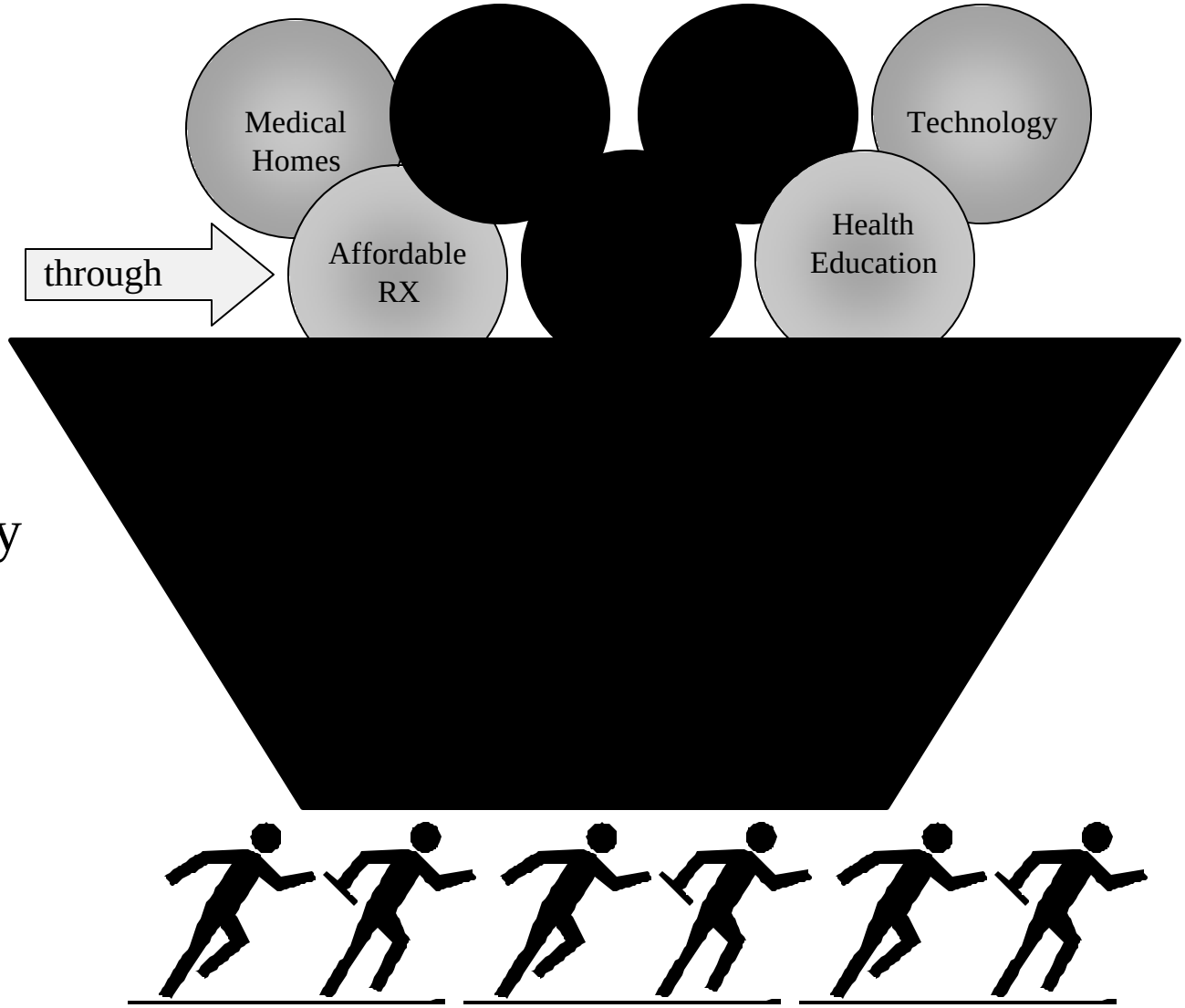
  ✓Benefit
  ✓Value
  ✓Savings

- Interventions must be defined and “costed out”
- Outcomes must be linked to dollar values

Return on Community Investment

INTERVENTION	TYPES OF BENEFIT, VALUE, SAVING	BENEFIT, VALUE, SAVINGS	MEASURE-MENT OF COSTS	SAVINGS-BENEFITS per 100 enrolled clients per year
Assuring enrollee has permanent medical home (primary care)	Avoided ED Visits for all enrollees	Savings = 37% less likely to have nonurgent ED visit (Petersen et al. 1998) 'Nonurgent Emergency Department Visits – The Effect of Having a Regular Doctor.' *Medical Care* 36(8):1249-55.	Savings = cost per ED visit $600 x .37 fewer visits = $222	**Savings $22,000 per 100/yr**
Enrollment of uninsured person into permanent health insurance	Improved annual job earnings	Benefit = Annual earnings increase 10-30% (Kaiser 2002). Sicker and Poorer: The Consequences of Being Uninsured.	Earnings = 20% increase in average salary of $25,000	**Benefit $500,000 additional earnings per100/yr**
Teaching health related self-management skills	Avoided hospitalizations and days for all enrollees	Savings = $750/yr (fewer hospitalizations) (Lorig et al. 1999) 'Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization'. *Medical Care* 37(1): 5-14.	Savings = $750 x number of clients receiving self-management skills	**Savings $75,000 per 100/yr**

Better Health through



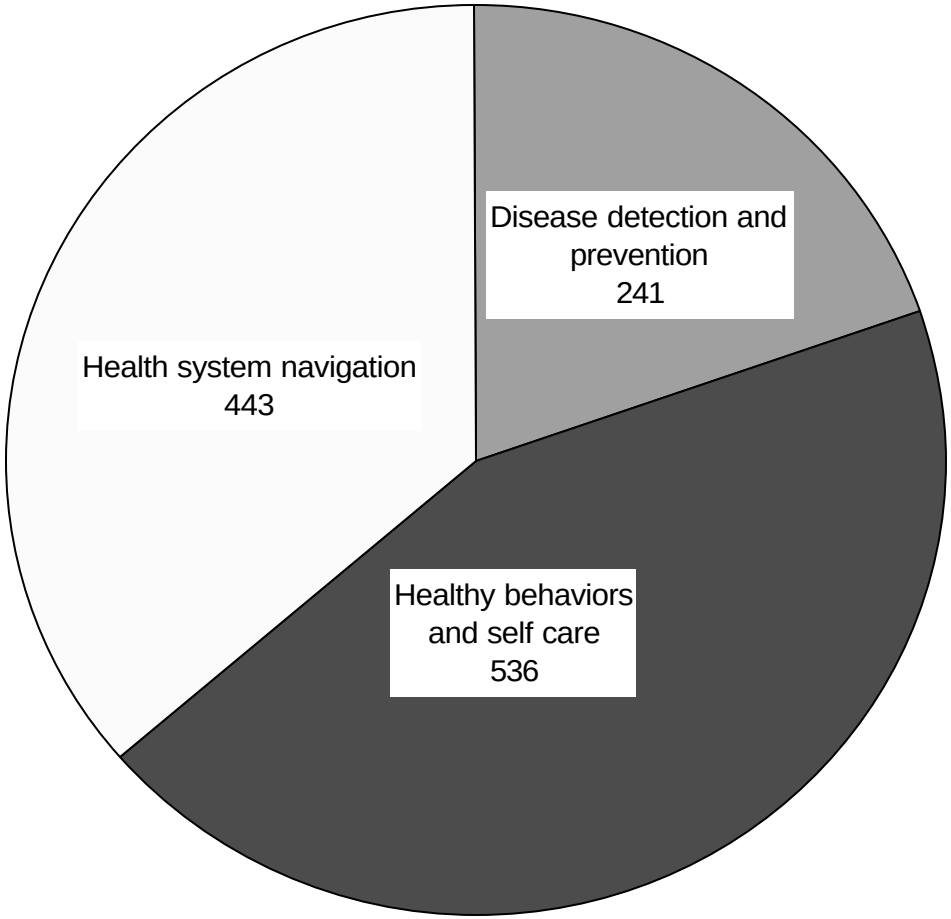
At *Less Cost* by

Better Health through education about how to take charge

1,220 Clients Received Health Related Education since 12/02

An additional 3,784 people were educated through community outreach efforts

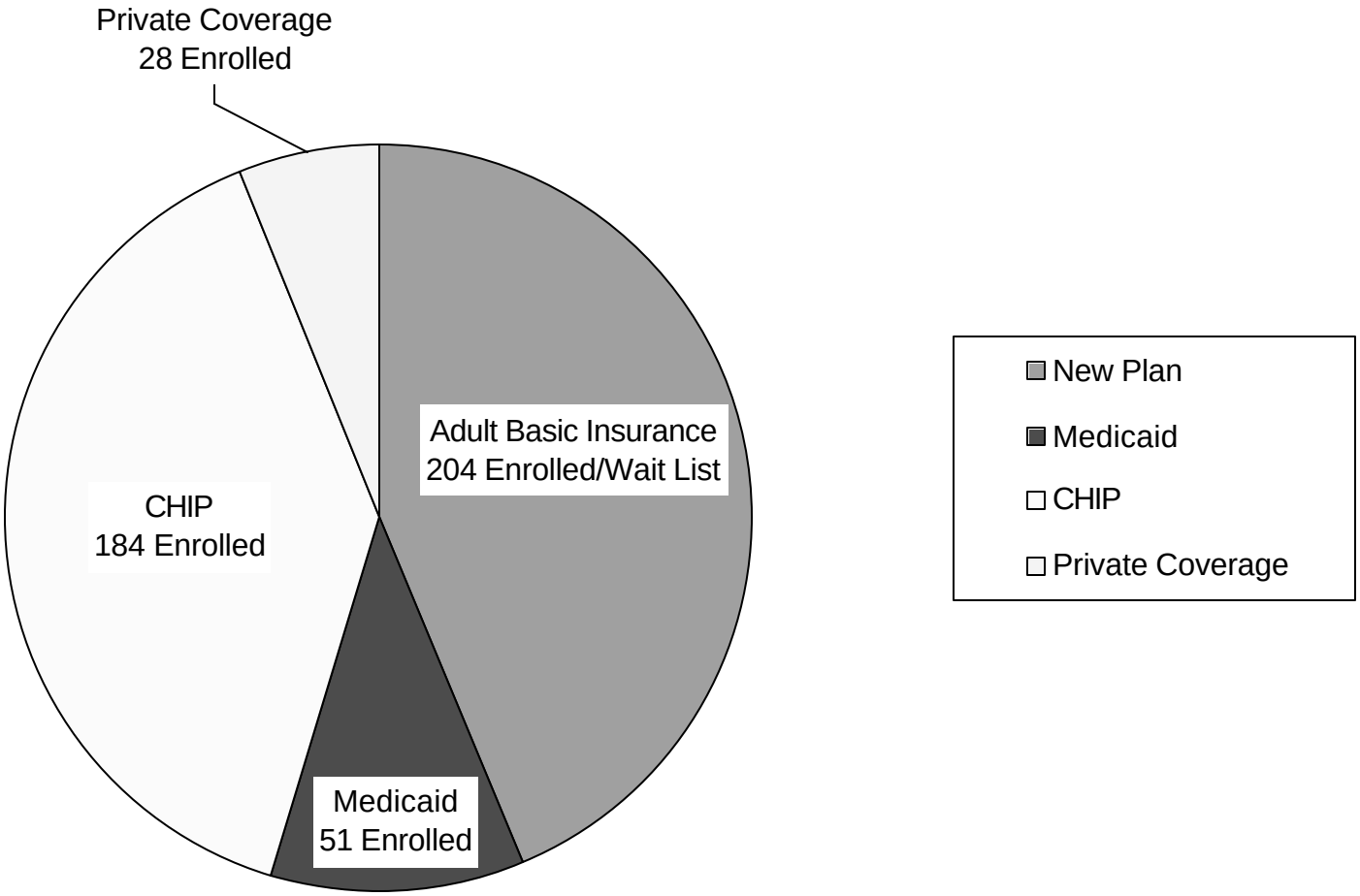
Savings = $ 402,000 in reduced hospitalizations by teaching self care



Better Health through affordable coverage

467 uninsured enrolled in affordable coverage since 12/02

Annual earnings increase when client obtains coverage and health status improves
Value = $1,157,243

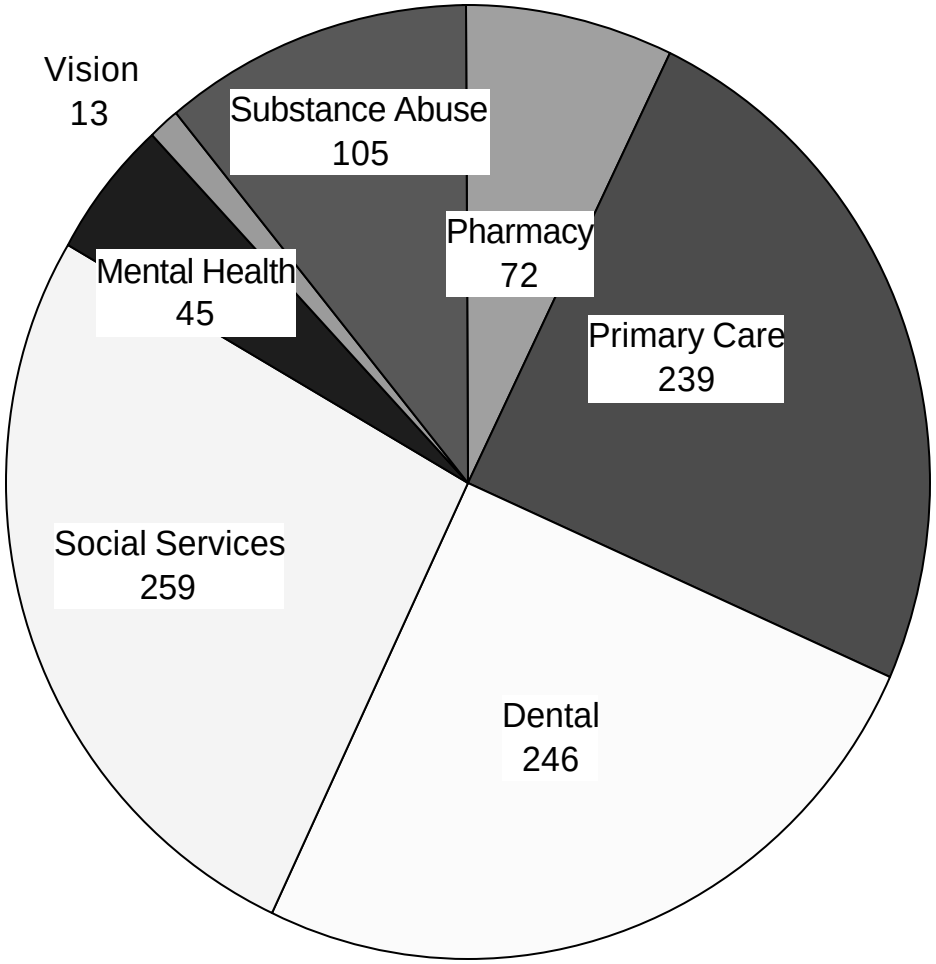


At Less Cost by reducing fragmentation

979 clients received facilitated referrals to necessary services since 12/02

76 clients needed interpreter services -Spanish language

Savings by having coordinated system of care vs. uncoordinated $1.07 million



Reinvestment in the Community

- Increased Collaboration.
- Increased Enrollment - CHIP, Medicaid, etc.
- Coordinated availability of information on the care to underserved populations.
- Coordinated management of care and prevention services.
- Decreased utilization of inappropriate resources.
- A healthier community.

Healthy Northeast ACCESS PROGRAM

ROYAL TECHNOLOGY GROUP

For additional information visit

www.healthyneaccess.org

or

www.scrantonrtg.com

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